NORTHLAND DHB REVIEW OF COMMUNITY PODIATRY SERVICES

PURPOSE

To identify and understand the foot care pathway in Northland, assessing the level of risk to patient safety associated with the current management and coordination practices within the community podiatry service, and to recommend any required changes to eliminate unacceptable risk and/or identify opportunities to improve the service..

BACKGROUND

Over the past two years a number of concerns have been raised by Northland District Health Board's podiatrist in relation to the performance of the Community Podiatry Service in regards to clinical governance and performance, referral process and timeliness of referrals.

The Northern Diabetes Strategic Advisory Group (NDSAG) was formulated to provide the strategic oversight and governance required in relation to the Local Diabetes Team Service Specification. The group formed to provide clinical leadership in designing new models of care and demonstrate alliance across a multi-disciplinary team, while providing a forum for sharing and a process for dissemination of information.

In 2017 a complaint was lodged with the Health and Disability Commissioner regarding the treatment received by two patients of a community podiatrist. The complaint was assigned to Northland DHB who sought an investigation by the contract holder Te Tai Tokerau PHO. The investigation identified gaps in the referral process resulting in an unacceptable delay for treatment. The contract holder initiated immediate remedial actions including:

- Formulating a strict time frame guide whereby the period of time between assigned and received and received and accepted is a documented measure and depicts all activity which occurs and is visible to the PHO for audit purposes.
- A redirection of referrals – all referrals are sent to the PHO by the General Practices and assigned to a Podiatrist from there.
- A collaborative approach between the overarching group 'Northland Diabetes Operational Working Group (NDOW) and NDSAG across all spectrums and specialities of Diabetes care.
- The appointment of a Programme Coordinator to provide day-to-day coordination of the podiatry service and, using clinical skills will also be responsible for overseeing the programme with regards to ensuring patients enter and exit the service in a locality that is appropriate, timely and in accordance with the proposed treatment timeframe and guidelines.
- The investigation process, report findings and the remedial actions undertaken by the PHO and the on-going clinical and contractual oversight of NDSAG were found to be satisfactory.

There have been a number of recent podiatry service reviews and evaluations, but concerns still remain around whether there is sufficient clinical oversight of the management and coordination of the service, which may be causing unacceptable risk to patient safety, therefore this review has been requested by Northland District Health Board funder.

REQUIREMENTS OF REVIEW

- Assess the level of risk to patient safety under the foot care pathway currently being provided by the Community Podiatry Service in Northland
- Recommend any changes to eliminate unacceptable risk, including governance of this service.
- Identify and discuss any opportunities to improve the service.

TTTPHO, Community Podiatrists, NDHB Podiatrist, NDHB portfolio manager and GM PIPS

Names of Review Team: Michele Garrett (Auckland District Health Board) Neil Croucher (NDHB) **Date of Review: 08-10th October 2018**

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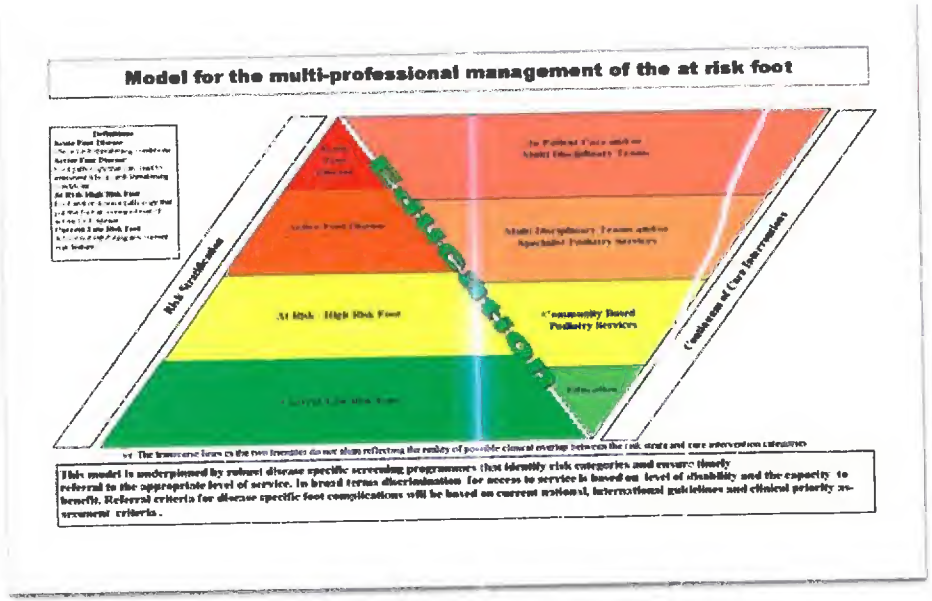
Podiatry Overview: Foot problems are a recognised serious complication of diabetes due to micro and macro vascular related changes. Various factors have been identified that contribute to a 'person with diabetes' (PWD) potential risk for developing a limb or life threatening foot problem. Five-year mortality rates after new-onset diabetic ulceration have been reported at rates higher than those of several types of common cancers. For PWD and a foot ulcer the 5 year mortality rate is 2.5 times higher than for PWD alone and it is greater than 70% for those that undergo a related lower limb amputation. For those requiring a lower limb amputation and receiving renal replacement therapy the mortality rate is 74% at 2 years.[1] These alarmingly high mortality rates should be acknowledged and providers of podiatry care should be considering ways to address this issue.

For a PWD the estimated life time incidence of foot ulcers is between 19% and 34%. The risk of foot complications can be stratified into low, moderate, high risk and active foot complications. A person identified with a low risk has a 99.6% chance of remaining ulcer free over two years whereas patients with a moderate risk have a 6 fold increased risk of ulceration. Patients with a high risk foot have an annual **83 fold** increased risk of ulceration.[2] In New Zealand statistics also show that Māori have an added risk factor for diabetes related lower limb amputation (DRLLA) with much poorer outcomes.[3-5] Based on this information a well-developed evidence-based 'National Diabetes Foot Screening and Risk Stratification Tool 2014' (NDFSRST) was published that offers comprehensive advice on foot screening and assessing risk status. The NDFRST includes Māori as a risk factor under high risk effectively moving Māori identified with moderate risk into the high risk category.[6] The NDFRST was updated in 2017 to include an Acute Foot in Remission category within the High Risk Foot cohort.



Podiatry Overview *(Continued)*:

The prevalence of foot risk is currently unknown in New Zealand as the risk screening and data collection varies between PHO. A Scottish study estimated that 69% were low risk, 20% moderate risk, 11% high risk and 4% of the high risk population had active foot complications.[7] A recent Waikato study found 13% of people were high risk for a diabetic foot and

22% were moderate risk and only 1% of the high risk population had active foot complications.[8] The lower rate of active foot problems in the Waikato study maybe due to it being undertaken solely in retinal screening clinics. This would exclude people with more severe retinopathy under the care of the eye clinic. This population is likely to have relatively higher rates of diabetic foot disease resulting in the study potentially underestimating the proportion of the population who have high or moderate risk feet.

Successful ulcer prevention strategies can be universally implemented based on rigorous risk screening and referral pathways to appropriately resourced foot protection services.[9, 10] New-onset diabetic foot ulcers should be considered a marker for significantly increased mortality and should be aggressively managed. The Ministry of Health Quality Standards for Diabetes Care 2014, Standard 11; recommends that access to foot care services is the basic expected care for people with diabetes. It is expected that all people with diabetes receive an annual foot check and this foot check is the basis for an integrated foot care service across primary and secondary services. [11]

Personal Comment from Reviewer and Co-author Neil Croucher:

"As a senior dentist with 30 years of experience working within publicly funded oral health services I had little previous interaction or knowledge of the podiatry profession and the level and type of services they provide to patients. During the 3 days of this review I have acquired a new understanding of how important feet are for everyday life and function. An unhealthy ulcerated foot in a patient already medically compromised by diabetes significantly impairs and impacts on the quality of life of individuals, and if left untreated can lead and contribute to the need for an amputation and/or an earlier than expected death. I believe the podiatry profession and the services they provide are undervalued and unappreciated by a large part of the health system. I am hoping this report will help to raise the profile of the important work they do and assist with the improvement of the current podiatry services and foot care pathways within Northland".

Standard	Performance Measure	Review Committee's Comments
Service Provision	▪ Podiatry Care is evidence based and current best practice. ▪ Podiatry care complies with the Podiatry Board Codes of Practice and regulations. ▪ Clinical Record keeping meets current professional and clinical guidelines and standards. ▪ Effective Internal and External Referral Pathways within region. ▪ Effective Intra-District Flow, Referrals and Pathways	There is a well-developed evidence-based National Diabetes Foot Screening and Risk Stratification Tool (NDFSRST 2017) that offers comprehensive advice on foot screening and the assessment of risk status. The NDFSRST also offers some guidance as to the level of service that should be offered to patients in the Low, Medium, High, Active Foot in Remission (AFIR) and Active Foot (AF) risk categories. AFIR and AF are subset categories of the high risk patient cohort. Recent research indicates that patients with a high risk foot (HRF) have an 83 fold risk of ulceration within a 1 year period whereas a moderate risk foot (MRF) has just a 6 fold risk of ulceration within 1 year. Both groups require podiatry care and oversight. High risk, AFIR and AF patient cohorts can require at least monthly podiatry visits (*or more frequently as clinical circumstances dictate*). The moderate risk cohort should receive bi-annual podiatry input.[1] The low risk group can be managed in a GP primary care setting, but still require education and an annual foot risk assessment. **Current Status of the Northland Foot Care Pathway:** ***Screening*** Screening helps to identify the risk status of the foot in relation to whether ulceration could occur in the future. In any cohort of patients with diabetes about 15% will be identified as having a HRF, 25% will have a MRF and about 60% will have a low risk foot (LRF).[12] Podiatry input is imperative for the HRF and important for the MRF. HRF patients with active ulceration or in remission require more intensive podiatry input, most of which should be provided by a senior and experienced podiatrist. Most low risk foot patients do not require direct podiatry input. Nearly all foot risk screening in Northland takes place as part of the Diabetic Annual Review (DAR). This review is carried out by GP practice nurses and is one part of the expected outcome framework for the Diabetic Care Improvement Package contract. There are still gaps in DAR coverage across Northland with only 59% of the known Diabetic Cohort in Northland having their DAR in the last 17/18 financial year. Of those that do have their DAR, around 80 to 85% received their foot risk screening also. This means roughly 50% of the type 2 diabetic patient cohort *(approx. 4200 patients)* did not receive their foot risk screen last financial year. Whilst many of these patients will be deemed low risk, there will still be a predicted **600** patients in the **high risk** foot group and 1000 patients in the moderate risk group that might not have been screened in the last financial year. We believe that other opportunistic foot risk screening programmes need to be introduced to improve coverage and assist GP Practices with the practicalities of getting 'hard to reach' patients in for their annual foot risk screening. Possibilities could include having a trained foot care assistant attached to the retinal eye screening programme and specialist eye, diabetic and renal clinics. Cross matching of databases would assist identifying and targeting patients that are overdue or due for their annual foot risk screening. Feedback to GP practices of those patients that have been screened in these alternative programmes would allow updating of their DAR's.

Standard	Performance Measure	Review Committee's Comments
		Foot Risk Assessment and Referral Pathways There are well developed, evidenced based risk assessment and referral processes at the GP practice level within Northland. These were developed recently by Te Tai Tokerau PHO (TTTPHO), and are closely aligned with the NDFSRST 2017. GP practice nurses seem familiar with the foot risk assessment forms and referral processes, but knowledge about the various referral pathways to and from primary and secondary podiatry care needs to be improved and strengthened. Also we felt that GP practice teams were not as aware as they should be about the urgency required for an active foot issue to be seen by the hospital podiatry service. GP practices with the latest 'evolution' version of Medtech seem to be are able to handle and process the foot risk assessment electronic forms and referrals in a more user friendly and efficient manner. We would recommend TTTPHO provides more frequent education sessions to update GP practices on the various foot risk categories, and in particular the referral processes and pathways for the high risk and AF categories. This is really important in the light of recent Datix incident reports suggesting unacceptable delays in referrals to hospital podiatry services for active foot complications. Reminding GP practices of the importance of annual foot risk screening and providing guidance around what advice should be offered to patients with a low risk foot should be covered too. We were slightly concerned to hear that the high risk foot group needed a new community podiatry referral from GP practice each financial year in order to receive ongoing community podiatry (CP) sessions. Also it was our understanding that this referral couldn't actually be processed without a completed DAR and annual foot risk assessment being completed by the GP practice. This is proving to be a significant barrier to ensuring the continuity of CP care for these high risk patients. Research evidence strongly indicates that almost all patients deemed as having a high risk foot patient will remain high risk indefinitely. We would like to see this administrational barrier removed so the high risk foot group can receive the continuity of podiatry care that they need. TTTPHO have responded positively to the concerns raised by Health and Disability Commission in August 2017, following a complaint that highlighted systemic issues around the oversight of the referral processes and pathways. Since January 2018 they have had a referral coordinator with nursing clinical experience triaging and overseeing the distribution of these referrals to the closest contracted community podiatrist. They have also developed good documentation to support the risk assessment screening and referral process that is founded on the National Diabetes Foot Screening and Risk Stratification Tool (NDFSRST). An internally commissioned evaluation in 2016 of the TTTPHO community podiatry service offers some general insights, with the SWOT analysis suggesting possible improvements and key issues and concerns that needed attention. The TTTPHO has addressed some of those concerns and made a few improvements. We believe more work still needs to be done, especially in terms of the overall model of care, the contracting model, insufficient number of funded podiatry sessions for the high foot risk category and the lack of clinical governance leadership and oversight of the contracted podiatrists and the podiatry care provided. ***Hospital-Based Specialist Podiatry Service*** Those patients with high risk AF issues (*active ulceration*) require more specialist podiatry services and are referred to the

Standard	Performance Measure	Review Committee's Comments
		High Risk Foot Clinic (HRFC) at Whangarei Hospital via the e-referral system from general practice. CPs don't have access to e-referrals and so the mode of referral and the referral pathway varies significantly. We believe this pathway is working well when it is utilised* and until very recently patients have been getting access to timely, evidence based and quality specialist podiatry services. Access to specialist podiatry is further enhanced by the willingness of the hospital podiatrist to offer regular clinics at outlying community hospitals at Kaitaia, Bay of Islands and Dargaville. However the case load of the hospital podiatrist has been steadily increasing over recent years and has reached a point where additional hospital podiatrist FTE is urgently required: This is not just to meet the increasing demands on the service but to safeguard the wellbeing of the hospital podiatrist, who we believe is under significant stress and pressure trying to meet the current demands on the service. ** Alarmingly however recent audits had suggested that 70% of people that proceed to amputation had not been seen by the HRFC.* The orthotic service is co-located with the High Risk Foot clinic at Whangarei hospital. This ensures a close relationship between the hospital podiatrist and the orthotic service allowing for excellent and timely care to be provided for those high risk foot podiatry patients that need orthotic support. We commend this co-location and the state-of-the-art clinic environment that has been created as a result. The orthotic service, with the addition of a newly appointed orthotist, seems to have the capacity and the collegial relationships to meet most of the current demands and requests of the hospital and community podiatrists. ***Community Podiatry Service*** Those patients with a moderate or high risk (*non-ulcerated*) foot are referred from GP practices to the TTTPHO community podiatry service. Referrals are triaged by a registered nurse whose role is to coordinate the referral to individually contracted community podiatrists, as near to where the patient lives or goes to work as possible. There is generally good geographical coverage of the community podiatrists across Northland. However there does not appear to be consistent access to a TTTPHO contracted provider in the Mangawhai and Kaiwaka areas for PWD domiciled in NDHB area but enrolled with a WDHB GP practice. Contracting is based on domicile but referrals are via GPs to their associated PHO. In saying that there may be some inter district podiatry cover from the Waitemata DHB podiatry services which we may be unaware of. In general most patients referred to the community podiatrist (CP) under this model of care are getting between 1 and 2 funded CP visits. Additional sessions can be requested by CP's through the TTTPHO referral coordinator which can result in one or two more sessions being approved for higher risk patients within each financial year. For the high risk foot group the number of funded podiatry session's falls well below the evidence based recommendation of approximately 12 podiatry sessions a year. Patients discharged from the HRFC to the community podiatry service can be referred for treatment, based on the discharge recommendations. The current referral pathway only allows for the initial visit and then the podiatrist needs to request further treatments based on their suggested care plan and the newly formulated Podiatrist Treatment Guidelines. The treatment guidelines have been formulated trying to take into account the patient's medical risk and an attempt has been made to rationalise the care provided based on patient acuity. No preventative treatment strategies such as referral for orthoses, footwear and surgery have been included. They do not appear to be evidence based and the reviewers feel they require further work to ensure that patients are receiving the right level of care. Having to request additional treatments at the first visit means that the care plan cannot be agreed to with the patient at the consultation also additional appointments cannot be made as funding availability is uncertain. The addition of another level of gate keeping at this point could potentially create barriers to continuity of care and increase the administrative burden for the

Standard	Performance Measure	Review Committee's Comments
		CPs. We did note however the high level of goodwill amongst the contracting podiatrists, who seemed to be providing additional sessions for the high risk group at greatly reduced private fee rates or sometimes without any remuneration. This we felt was a clear sign that the current publicly funded model of care was not delivering the care needed for those in the high risk foot groups. The podiatrists also indicated varied approaches to in-depth diabetic foot assessments and patient engagement strategies. The current funding and contracting model doesn't support or recognise the need for community podiatrists to engage and attend peer group activities and clinical governance forums. The result of this is isolated practitioners with little peer support or oversight. With several of the contracted podiatrists being relatively new graduates this does give us great cause for concern. **Summary** In summary therefore we have the following comments about the current Northland Foot Care Pathways and podiatry model of care that need to be considered or require addressing. • The number and allocation of publicly funded CP sessions are woefully insufficient, especially for the high risk foot group. • New opportunistic foot risk screening programmes, to improve the annual foot risk screening rate and coverage throughout Northland, should be introduced as soon as practically possible. (*eg: Appropriately trained foot care/health care assistant attached to the retinal eye screening programme as well as the specialist eye, diabetic and renal outpatient clinics*). • Eliminating the need for the high risk foot group to require a new community podiatry referral from GP practice each financial year, which at present is a significant barrier to the continuity of care for these patients • Further work is needed on the Podiatry Treatment Guidelines and how the clinical expertise of the podiatrists could be used to implement appropriate care plans. • More frequent GP practice education sessions are needed around all aspects of the foot care pathway. (*Updates, guidance and advice on referral processes and referral pathways for each foot risk category)* • We did not feel confident that TTTPHO have a clinical monitoring and quality assurance mechanism in place to ensure all contracted community podiatrists were working to the expected Podiatry Board Codes of Practice and regulations: other than the need for a valid Annual Practising Certificate. Service standards and a credentialing framework need to be urgently developed for contracted CP's. • Community Podiatrist are working in isolation and need to be supported to create or attend peer group activities and clinical governance forums. • We were not assured that all contracted CP's had the necessary equipment to carry out the expected non-invasive vascular assessment. • The foot care pathways for patients living near Northland's southern border *(Mangawhai and Kaiwaka)* are not clear and could mean some patients are not receiving the podiatry care they require. Inter district Podiatry and GP practice arrangements and funding will need further investigation. • Insufficient emphasis is being placed on the allocation and targeting of funded care packages to high risk foot patients over and above those with moderate risk. • Community Podiatrists do not have access to the e-referral pathway. This is resulting in an unacceptable variability in the quality and timeliness of referrals to the hospital based podiatry service.

Standard	Performance Measure	Review Committee's Comments
		• There is a variable and dysfunctional referral pathways from the hospital podiatrist back to community podiatrists for AF patients who have been successfully treated and are then re-categorised as an AFIR patient. (*It is recognised these patients in remission have a very high risk of relapse for future skin breakdown and ulceration and need even closer supervision, oversight and care from a podiatrist than a high risk foot patient who hasn't as yet had an ulcerative episode.)*
Internal Clinical Governance Activities	Evidence that the following quality activities are taking place: ▪ Professional Accountability ▪ Peer Review ▪ Clinical Audit ▪ Performance and Practice Appraisals ▪ Self-Assessment ▪ Dissemination of good practice ▪ Learning from our mistakes ▪ Continuing Professional Development ▪ Clinical and Non Clinical Risk Management *(Incident management)* ▪ Patient Satisfaction ▪ Positive Complaints Management	The Northland Diabetes Strategic Advisory Group morphed out of a previous group called the Northland Diabetes Operational working group. This change in emphasis and name intended to try and provide some more strategic oversight of the diabetic care pathways. We believe this group lacks the functional links and relationships to the funders and contract holders to be truly successful in monitoring and improving the diabetic foot care pathways, quality of care and the ongoing professional development and oversight of the community podiatry team. We would like to see this group provide more effective clinical leadership and clinical governance over the Northland Diabetic Care pathways, including that of podiatry services.
Legal requirements understood and followed	Organisation and Podiatrists understand and comply with ▪ HPCA Act ▪ Health & Disability Service ▪ Consumer Rights ▪ Medicine & Misuse of Drugs Act ▪ Privacy Act & The Health Information Privacy Code ▪ Occupational Health & Safety legislation	As mentioned before we were slightly concerned by the lack of clinical mentoring, monitoring and oversight to ensure all community podiatrists were working to the expected Podiatry Board standards of care.

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Healthy and Functional Relationships throughout the organisation	▪ Effective communication and relationships between referrers, podiatrists, PHOs and NDHB	There appeared to be good functional relationships between the TTTPHO and the GP practices under their oversight. The individual fee per visit contractual relationship with community providers was working in terms of invoicing and payment. However relationship building between the PHO and community podiatrists beyond just a contracting relationship didn't seem to be evident. Collegial and professional relationships and communication between the Hospital and Community Podiatrists was evident but could definitely be improved. Heavy clinical workloads and lack of funded non-clinical time for podiatrists may be contributing factors to this.
Cultural Awareness and Competency	▪ The organisation and podiatrist understand and embrace the principles of the Treaty of Waitangi. ▪ The organisation and podiatrist shows cultural competence in the way they operate and deliver care ▪ The organisation and podiatrist are ensuring Māori and Non-Māori are receiving equitable access to quality podiatry care	It was difficult in the short time of the review to make a judgement on cultural awareness and competency of the podiatry service. The TTTPHO clearly have this as a very strong objective and expectation for all their employees and contractors. In terms of the 3 community podiatrists we did meet, 2 out of 3 were Maori, both of whom had come back home to Northland after their podiatry training to live and work amongst their own communities and Whanau. This was an encouraging observation in terms of Maori workforce development.
Discussion points - **Level of risk to patient safety** - **Areas of Concern**	The current model does not appear to support seamless care with clear clinical oversight and responsibility for the foot health of people living with diabetes. This in part could be due to contracts being administered by separate directorates within the DHB. The hospital and community podiatry service is therefore managed and delivered by different services and disparate practitioners. Connected care is further hindered by varying isolated patient management systems used by the community podiatrists and the lack of integration between secondary services and primary care IT tools. We don't believe there is sufficient emphasis and targeting of the high risk foot group in the current community podiatry service delivery model of care. The current funding package and contracting model for community podiatry is not sufficient to provide the appropriate evidenced based level of podiatry care to all high risk and moderate risk foot patients in Northland. There is insufficient hospital based podiatry to meet the current and predicted Active Foot Cohort demands on the hospital podiatry service. There are specific concerns about the cohort who are deemed AFIR (Active Foot in Remission) following their discharge from the hospital podiatrist service. We are not confident this important cohort of patients are receiving the essential and regular podiatry follow up and input they require to reduce the risk of re-ulceration. We believe this specific group of patients should be cared for by the hospital based podiatry team, to ensure these patients are carefully monitored, treated and not lost to follow up. Community Podiatrists are working in isolation and there does not seem to be any active podiatry group that might be able to provide a forum for peer interaction and discussion. The foot care pathways for patients living near Northland's southern border (Mangawhai and Kaiwaka) are not clear and may mean some patients may not be receiving the	

	podiatry care they require. Contributors to this may be related to the inter district GP practice and intra district funding arrangements. More robust clinical governance for the podiatry programme is required and the development of service standards and a credentialing framework is required
Actions and Recommendations	**We would recommend the six points below are considered and actioned under one of three proposed models of care.** **1) Additional hospital specialist podiatry FTE capacity is created in order for the hospital podiatry service to meet its current and future demands.** **2) The hospital podiatry service provides continuing care to all patients with Active Foot, Active Foot in Remission and end stage renal failure.** *(This will need additional salaried podiatry FTE offering extra regular clinics within community hospitals and other appropriate health care clinic facilities throughout Northland)* **3) The community podiatry service is reoriented and sufficiently resourced to ensure the high risk foot cohort can access free or subsidised podiatry services on a monthly basis if required as per evidence based guidelines.** **4) Develop new opportunistic foot risk screening programmes across Northland to improve the annual foot risk screening coverage, especially for the group of patients who are, or likely to be, in the high risk foot group.** **5) Effective clinical leadership and clinical governance of the community podiatry services needs to be developed, to include service standards and a credentialing framework.** **6) If resources allow, the continuation of a free or subsidised community podiatry service for the moderate foot risk group of patients, at a frequency of one or two sessions per year.** **Model of Care Option A:** Centralised contract that is managed by the High Risk Foot service within the Medicine, Health of Older People, and Emergency & Clinical Support directorate. **Model of Care Option B:** Mixed Model with High Risk Foot service being responsible for the Active Foot, Active Foot in Remission and end stage renal failure and the HRF and MRF contracts are managed by TTPHO **Model of Care Option C:** Mixed Model with High Risk Foot service being responsible for the Active Foot, Active Foot in Remission, end stage renal failure and the HRF. The MRF contract is managed by TTPHO
Next review date	**In the light of the content of this report we would recommend a review and evaluation of podiatry services in about 3 years' time.**

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Report Authors

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Date: 11/12/2018.

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Date: 04/12/18

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Te Tai Tokerau PHO Documentation

DCIP-Podiatry-stepp
ed-care-incl-flow-cha

DCIP How to Record
a Diabetes Foot Risk

DCIP How to Refer
to Podiatry v2.pdf

NDSAG ToR 2017
V3.pdf

NZSSD guidelines.pdf

Podiatry Contract
master service specs

Podiatry Treatment
Guidelines Overview (

Risk categories for
Podiatry treatment gu

Feedback from Te Tai Tokerau PHO

Podiatry risks and
issues with resolution

Previous reviews

Northland PHO
Community Podiatry F

TTTPHO Carolyn
Jones 2016 Review.p

References

1. Armstrong, D.G., A.J.M. Boulton, and S.A. Bus, *Diabetic Foot Ulcers and Their Recurrence.* 2017. **376**(24): p. 2367-2375.
2. Leese, G.P., D. Stang, and D.W. Pearson, *A national approach to diabetes foot risk stratification and foot care.* Scottish Medical Journal, 2011. **56**(3): p. 151-155.